

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

9 7 - 2 9

2. STATE:

Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

December 30, 1997

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR

7. FEDERAL BUDGET IMPACT:

a. FFY 98 \$ 1,047b. FFY 99 \$ 1,395

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A Appendix B Pages 2, 5,
Attachment 4.19A Page 9A9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):Attachment 4.19A, Appendix B Pages 2, 5,
Attachment 4.19A Page 9A

10. SUBJECT OF AMENDMENT:

This amendment removes the comparison of Inpatient cost to Inpatient payments for final
settlements, and references Appendix B for the final settlement methodology.

11. GOVERNOR'S REVIEW (Check One):

- ☒
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Gary J. Stangler

14. TITLE:

Director, Department of Social Services

15. DATE SUBMITTED:

12/22/97

16. RETURN TO:

Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

12/23/97

18. DATE APPROVED:

JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

12/30/97

20. SIGNATURE OF REGIONAL OFFICIAL:

22. TITLE:

ARA for Medicaid and State Operations

21. TYPED NAME:

Thomas W. Lenz

23. REMARKS:

SPA CONTROL

Date Submitted 12/22/97

Date Received 12/23/97

2. The state agency shall review audited Medicaid-Medicare cost reports for each hospitals fiscal year in accordance with Appendix B.

E. Adjustments to Rates

The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the Medicaid agency from imposing any sanctions authorized by any statute or regulation;
2. When rate reconsideration is granted in accordance with subsection V.F.;
3. When the Medicare per-diem rate is changed by the servicing fiscal intermediary based on a new audit finding for the base year. This adjustment may be applied and effective no earlier than the first day of the month following notification by the Division of Medical Services; and
4. A sole community provider re-opening or adding certified acute care beds after October 1, 1992, who incurs additional costs for the purpose of providing inpatient acute care services in a community where inpatient acute care services were provided in state operated facilities, which are discontinued after October 1, 1992, will receive a rate increase for the additional cost incurred, not to exceed twenty three and four tenths percent (23.4%) of the inpatient acute care rate in effect on October 1,

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Supersedes TN# 97-15

Effective Date Dec 30, 1997
Approval Date JUN 06 2001

Substitute per letter dated 5/17/61

Attachment 4.19-A
Page 24

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

State Plan TN # 97-29
Supercedes TN # New Material

Effective Date 10/01/97
Approval Date JUN 06 2001

- (E) Outpatient Services/Cost. Reimbursable outpatient services or costs are services or costs that are provided prior to the patient being admitted to the hospital. Only outpatient services or cost which are reimbursed on a percentage of charge as defined in 13 CSR 70-15.010 will be included in the final settlement, unless they are excluded elsewhere in this regulation.
 - (F) Routine Cost Center. A routine cost center is an Adult & Peds Unit, Subprovider Unit, Nursery Unit or Special Care Unit;
 - (G) Special Care Unit. A special care unit is a hospital unit that furnishes services to critically ill inpatients. Examples are Intensive Care Units (ICU), Coronary Care Unit (CCU), or Neonatal Care Unit. The ICU unit may be for only one (1) type of patient or for all critically ill patients.
 - (H) Paid Days. Paid days are the actual number of days paid for inpatient services on claims with the first date of service within the fiscal period of the cost report;
 - (I) Routine Charges. Routine charges are the charges billed by the hospital for the care provided to the patient in a routine care center. These services are normally provided to all patients in the hospital;
 - (J) Ancillary Charges. Ancillary charges are the charges billed by the hospital for services that are not routinely provided in the routine care center and are not provided to all patients.
 - (K) Private Room Day. A private room day is a day when due to the patient's medical condition it is determined that the patient should be alone in a room.
- (3) Inpatient settlements will be calculated based on paid day hospital services after the Medicare/Medicaid cost report is received from the Fiscal Intermediary. Based on this settlement the Division shall make any recoupments necessary to ensure that Title XIX Medicaid payments for inpatient services do not exceed allowable inpatient Medicaid charges. This settlement shall not result in additional payment to the hospital if its cost exceeds its payments. This settlement will be determined in the following manner:
- (A) Data will be gathered from the Medicaid inpatient claim history for paid days by routine cost center; private room days; routine charges; charges for each ancillary cost center; and inpatient payments for claims with first date of service in the cost report period;
 - (B) The Division will extract the following data from the cost report received from the Fiscal Intermediary:
 - 1. The total patient days from worksheet S-3 for each routine cost center and observation bed days. The total patient days for Adults & Peds may be adjusted for labor and delivery room days reported on questionnaire, if not included on worksheet S-3;

3. The total payments from paragraph (3)(D)2.A., B., C., and D., will be subtracted from the lesser of the total cost in paragraph (3)(D)1., or the Medicaid charges from subsection (3)(A) (except hospitals identified by Medicare as a nominal charge provider for that fiscal year shall have their settlements based on cost). If the lesser of cost or charge exceeds the payment, no additional payment is due the hospital. (The inpatient settlement is zero (0) under the prospective payment plan.) If these payments exceeds the charges the difference will result in an overpayment which will be due from the hospital. (Disproportionate share payments are waived from the overpayment determination.)
- (4) Outpatient hospital settlements, Provider Based Rural Health Clinic (PBRHC) settlements or Provider Based Federally Qualified Health Centers (PBFQHC) settlements will be calculated after the Division receives the Medicare/Medicaid cost report with a Notice of Provider Reimbursement from the hospital Fiscal Intermediary.
 - (A) The Division of Medical Services shall adjust the hospital's outpatient Medicaid payments, PBRHC PBFQHC Medicaid payments (except for those hospitals that qualify under subsection (4)(B), whose payments will be based on the percent of cost in (4)(A)1., or 2. for:
 1. Services prior to January 5, 1994, the lower of eighty percent (80%) of the outpatient share of the costs from subsection (4)(D), or eighty percent (80%) of the outpatient charges from paragraph (4)(C)1.;
 2. Services after January 4, 1994, the lower of ninety percent (90%) of the outpatient share of the cost from subsection (4)(D), or ninety (90%) of the outpatient charge from paragraph (4)(C)1.;
 3. PBRHC and PBFQHC shall be reimbursed 100% of the lower of its share of the cost in subsection (4)(D) or its charges in paragraph (4)(C)2.
 - (B) A facility that meets the Medicare criteria of nominal charge provider for the fiscal period shall have its net cost reimbursement based on its cost in subsection (4)(A)1., or 2.
 - (C) The Medicaid charges used to determine the cost, and the payments used to determine the settlement will be:
 1. For outpatient services the charges and payments extracted from the Medicaid outpatient claims history for reimbursable services paid on a percentage basis under 13 CSR 70-15.010.

State Plan TN# 97-29
Supersedes TN# 94-22

Effective Date Dec. 30, 1997
Approval Date JUN 06 2001

**INSTITUTIONAL STATE PLAN AMENDMENT
ASSURANCE AND FINDING CERTIFICATION STATEMENT**

STATE: Missouri

TN - 97-29

REIMBURSEMENT TYPE: Inpatient hospital X

PROPOSED EFFECTIVE DATE: December 30, 1997

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253 (b) (1) (i) - The State pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. _____
2. With respect to inpatient hospital services - -
 - a. 447.253 (b) (1) (ii) (A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. _____
 - b. 447.253 (b) (1) (ii) (B) - If a state elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861 (v) (1) (G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861 (v) (1) (G) of the Act. _____

If the answer is "not applicable," please indicate:

Dep JUN 06 2001

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- c. 447.253 (b) (1) (ii) (C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. _____
 - 4. 447.253 (b) (2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:
 - a. 447.272 (a) - Aggregate payments made to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. _____
 - b. 447.272 (b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) - - when considered separately - - will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. _____

If there are no State-operated facilities, please indicate "not applicable:" _____
 - c. 447.272 (c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42CFR 447.296 through 447.299.
 - d. Section 1923 (g) _ DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act. _____

B. State Assurances. The State makes the following additional assurances:

- 1. For hospitals - -
 - a. 447.253 (c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital -indebtedness, return on equity)if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

3. 447.253 (e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates. _____
4. 447.253 (f) - The State requires the filing of uniform cost reports by each participating provider. _____
5. 447.253 (g) - The State provides for periodic audits of the financial and statistical records of participating providers. _____
6. 447.253 (h) - The State has complied with the public notice requirements of 42 CFR 447.205. _____

Notice published in Missouri Register on:
If no date is shown, please explain:

July 1, 1997

7. 447.253 (i) - The State pays for inpatient hospital services using rates determined in accordance with the methods and standards specified in the approved State plan. _____

C. Related Information

1. 447.255 (a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Hospital

For hospitals: The Missouri Hospital Plan includes DSH payments in the estimated average rates. However, the DSH payments included in the estimated average rates do not represent the total DSH payments made to hospitals under the Missouri Medicaid Plan.

Estimated average proposed payment rate as a result of this amendment:
\$752.90

Average payment rate in effect for the immediately preceding rate period:
\$752.90

Amount of change: \$00.00 Percent of change: 0.0%

2. 447.255 (b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:
- (a) The availability of services on a statewide and geographic area basis:
This amendment will not effect the availability of short-term or long-term services.
 - (b) The type of care furnished: This amendment will not effect hospital services furnished to Medicaid eligibles.
 - (c) The extent of provider participation: This amendment will assure recipients have reasonable access taking into account geographic location and reasonable travel time to inpatient hospital services.
 - (d) For hospitals - - the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs:
It is estimated that disproportionate share hospitals will receive 100% of its Medicaid cost for low income patients with special needs.